Readiness to Change in PTSD Treatment 2
Written Video Transcript

Now, why might PTSD patients be unaware of the need to change? I think one important thing is that trauma symptoms feel right, and I'm going to make an argument that particularly criterion C and D symptoms, avoidance symptoms and arousal symptoms, feel right. They feel appropriate ways [00:00.20.00] to deal with life, especially with issues of safety. And we have heard many times as we've worked with our patients, we've heard many times when we talk about, you know, what's normative and, you know, where do you think you lie in terms of your hypervigilance or the amount of weapons you have [00:00.40.00] or the type of perimeter you've set up around the house, the phrase we hear is, "Oh, the average guy's stupid, he's careless, doesn't know, he doesn't know how bad it is." So, this is very informative in terms of, you know, how people are thinking about their symptoms and I don't think [00:01.00.00] they're seeing them as symptoms. All right, and we talked about some of those, even avoidance of trauma reminders. Now, there are other reasons that someone can be unaware of a serious problem. Again, this is true for all of us, true for all types of patients, not just PTSD patients. [00:01.20.00] A lot of patients don't know behavior norms. What's normative behavior? And I think that turning 18 does not mean you suddenly become aware of all the odd behaviors you observed and grew up with in your family. You don't suddenly say, "Oh yeah that's pretty weird," or "People don't do that," or "That's not okay." [00:01.40.00] All right, you might feel bad about it, you know, but in terms of getting a general sense of what's okay or what's normative a lot of people, includes us, were things that we may be precontemplators or contemplators on. We don't know the norms for the behavior. And I think this is particularly true [00:02.00.00] for our guys where this applies is military training at an early age and then combat for a long time, for the Vietnam vets in particular, and then post-military life. You know, the guys we see at VAs they've lived a pretty tough life style with a pretty rough crowd for 30 years. [00:02.20.00] And so when you ask patients about what's normal the answers are pretty surprising 'cause they've only hung out with a pretty rough crowd, hard drinking crowd, using drugs, a lot of violence, not a love—not a lot of love and affection in relationships and people tend to chose partners that support their pathology, right? [00:02.40.00] And so I think this is very important. The second issue why someone would be unaware of a problem is that they may not be aware of the negative consequences and that certain levels of negative consequences are not normative. How much time you spend in jail, this is a big problem in inner cities. [00:03.00.00] It's normative, it's expected to go to jail. And that's true for a lot of our guys in terms of how much violence they see or interpersonal distance, time alone, things like that. I think also there's a lot of roadblocks to admitting a problem to yourself. Now, my theoretical tendency is to believe [00:03.20.00] in an avoidance model, that people who do not acknowledge a problem to themselves are avoiding some sort of fear. And there's a lot of issues that you have to face if you admit a problem. Think of medical patients who, you know, will not admit they have a heart problem,

won't take the meds. For a lot of patients [00:03.40.00] they don't want to feel that fear about that loss of control, or fears about incapacity, fears of imminent death or whatever they have. If you can sort of deny you have the problem then you wont have to face those fears. Also, with regard to this last section, internal roadblocks, a lot of people have [00:04.00.00] what we call internal stereotypes of people with problems. So, for example, for our guys who grew up in the '50s their exposure in the media to people with psychiatric problems, as you can imagine—The Snake Pit, I think, is one famous [00:04.20.00] movie. But their exposure to psychiatric hospitals is not a pleasant one. Then they come back from Vietnam, and I think in 1972 the most famous movie about psychiatric hospitals is One Flew Over the Cuckoos Nest. Alright, so the guys are a little scared about asking for psychiatric help after that [00:04.40.00] because they have internal stereotypes about what it means to be a psych patient. Someone says, "You've got psychiatric problems," it doesn't fit their stereotype in terms of how crazy someone might be or how much, you know, they need to be strapped down. That's also true for alcohol, for anger problems. A lot of times [00:05.00.00] guys have internal stereotypes that are of their dad, and you know very much have hated their dad for an anger problem or something. Someone says, "Well, you've got an anger problem," they're comparing themselves to the dad, and they may not fit the dad. But that's what they think when they hear "anger problem." So that's why someone can be aware—unaware of a serious problem. [00:05.20.00] Again, I'm not using "not ready," "in denial", those kinds of terms. Trying to take another look at this. Now, why PTSD patients might be ambivalent about changing, this is more about ambivalence than awareness, and as I mentioned before the pros are outweighing the cons. [00:05.40.00] And I think that's a reasonable approach to understanding why someone—yeah maybe they start to think there's a problem but they're not quite, not quite decided that, okay, it 's time to change. Other reasons for ambivalence, people might think they need to change [00:06.00.00] but to have to admit it publicly they're going to be ambivalent about changing. And there's a lot of reasons for this, shame, humiliation. A lot of guys have been trying to argue with their family and friends that they're right all along for the way they've handled, you know, work or business. Right for a lot of guys who are always have to be [00:06.20.00] in control, right, always in charge, rough on anybody work—you know, after 30 years they're going to have to say, "Oh, I was wrong the whole time, and you were right." That's a big roadblock to acknowledging ambivalence. A lot of our guys, they're afraid of being judged as damaged or weak. So, they may think there's a problem and believe it [00:06.40.00] but they're not going to acknowledge it. Okay. For a lot of guys, there's secondary gain of course, disability compensation. To make actual change, this is a very, very big issue. I want to touch on part of it. To give up disability, or to put it at risk, to admit certain problems, or to take responsibility [00:07.00.00] for problems. And also there's a great deal of family disruption when patients have to admit or take responsibility for problems or part of a family problem. The other thing that I don't have on here is that I think we underestimate the realistic concerns that patients have about admitting a problem as we push them to see something. [00:07.20.00] But for a lot of our patients there are tremendous issues around confidentiality. I wonder how many of you would feel confident about statements about confidentiality if you were admitted to the VA hospital, right? The VA does a good job but you know that it's still a large organization,

and your paperwork goes to different offices. I'm not saying anything untoward happens, [00:07.40.00] it's just that, you know, it's a big organization. So our guys are concerned about confidentiality especially for admitting some problems that they may be ashamed of. Partner reactions, jobs, not so much for the inpatients who tend to be out of work, but these are realistic concerns. And we need to listen to our patients sometimes when they're going to [00:08.00.00] tell us why they're not going to admit something. Okay, what are the treatment outcome implications of a stage of change model? First of all, the most basic assumption that we're going to talk about here is that treatment failure when therapy doesn't work is due to a therapist [00:08.20.00] or a program misreading the patients stage of change. Now, in terms of follow up, all right, if we're looking at how people are doing afterwards—and I'm going to talk about, you know, why people fail after treatment—I'm assuming that patients have gone to follow up appointments, are taking their meds, and any significant co-morbid conditions are being dealt with, all right? [00:08.40.00] Because those are all predictors of treatment failure also. But given that, and assuming those things are taken care of, I'm going to suggest that one important variable here is that programs misread, or ignore, stages of change. They mismatch interventions to the patient's level of [00:09.00.00] stage of change. Right, so they're giving homework to people who are precontemplators, right? They put somebody who's in an emotion management group, anger management group—if they're a precontemplator or contemplator, you know, they might be compliant and most of our patients are reasonably cooperative, right? They're not going to tell you that they're not buying any of this. [00:09.20.00] They're not buying any of it. And I think what happens is they leave treatment really not convinced that they need those skills because they've been mismatched. And the patient hasn't been in that group when they've been most convinced they really need it. I'll talk more about that. One thing I'm not going to talk about today that I think we tremendously underestimate is how much [00:09.40.00] there's a breakdown in therapeutic relationship between therapist and patients, especially in large hospitals and that some of the fundamentals about building therapeutic alliance. And a lot of therapists, and a lot of research shows that the best predictors of treatment—no matter what cognitive behavioral intervention you did—the best predictor was the degree [00:10.00.00] of expressed empathy by the therapist and how much the patient felt understood by the therapist when you measure those things, very important. I think we underestimate the power of therapeutic alliance. So, okay, so more about treatment outcome implications of a stage of change approach. Patients who exit treatment [00:10.20.00] unconvinced that old ways of coping and thinking are maladaptive, of course they're not going to see the need to use new coping skills. "Why do I need them? I'm going to just do what I did. That makes the most sense." Okay, and they're going to return to trauma based [00:10.40.00] coping. And of course they're going to look like they've done poorly after treatment in a treatment outcome study for post treatment adjustment, okay. Now, the flip side of this, if patients are convinced that a recurrence of a symptom after therapy, or their first reaction [00:11.00.00] to stressors, their first reactions would tend to be, you know, trauma based coping, if they're convinced that they're overreacting and that their response is because of something that happened to them in the past, whether it was Vietnam or child abuse or whatever, if they're convinced of that then what they're going to say is, "Oh, I've got this old problem [00:11.20.00]

flaring up. My old problem's flaring up." And they're either going to cope differently, or they're going to ask for help. And I think a lot of our patients don't do this because when they get back out there symptoms come back or stressors occur, they're not really convinced that the way they're coping with it is maladaptive. [00:11.40.00] It just feels right, as, as you might have heard me mention earlier. Okay, what I'd like to do is to talk about research findings but I want to take just a couple minutes to see if there are any questions about anything I've talked about so far [00:12.00.00] in terms of clinical and theoretical basis. Any, any questions or comments or thoughts about any of that? Okay, I'm hoping it has some relevance or sounds familiar to some of you. Yes, sir?

Could you say a little more about—wow that's loud—could you say a little more about educating patients who are precontemplative, [00:12.20.00] how you approach that?

I think it's important that you sort of breakdown the DSM-IV criteria a little more into reasonable day to day life terms, 'cause what patients will hear is hypervigilance or anger problems. But they're not going to see it as to the fact that they're hostile and mean all the time or dragging people out of cars on the highway. [00:12.40.00] And sort of reinterpreting the symptoms in real life terms that makes sense to the patient I think is an important thing to do with them. To review all the symptoms because the patients tend to talk about symptoms among themselves in a way that's going to most help them get disability compensation a lot of the time. A lot of times they don't [00:13.00.00] review all of the criteria or the ones that would be less helpful that they know they need to report on a form or an admission assessment. So, I think that's one of the things that I would do.

I'm thinking of the patients who either deny the extent of their symptoms, they'll say, "Oh yeah I lose my temper once in a while, but so does everybody," [00:13.20.00] or the patients who as, as you said before, will say the circumstances warrant that behavior so it's not a symptom.

That's right. Now that is very important because clearly those—I'm glad you said that. Those are signs of precontemplators, right. When you hear that, you've got to think precontemplation, all the way. [00:13.40.00] And you have got to step back, take a deep breath, and think, "I'm in for the long run with this person." Because my only goal, when you get somebody like this, your only goal with them is to get them to contemplation stage. It might take you six months. For you to hope for any more is ridiculous. But also to be realistic [00:14.00.00] that if you work with them, a little bit of education, a lot of reflective listening and empathy, more education about, "Well, let's talk about anger problems." Maybe some outside information, the norm comparison stuff too—although you're talking about cases where people aren't being quite up front about all the ins and outs of the problem. [00:14.20.00] But this is clearly someone you're not going to just do the education stuff with. You're going to have a long time of building a relationship with them so eventually they're going to be more open with you. That's also the time that you want to get family involved to say, "Well, you know, he's been in jail four times for pulling people off the highway who cut him off." Now, you know, patient can't deny it. Well, I mean, they can but you can get the [00:14.40.00] records or find out. And so, you

know, if you stay involved with people you get more collateral data also, I think, to help. But I think you'll get more data the more you build a relationship. And that's really the goal. You're thinking, "I've got nothing to do with this patient for six months but basically try to get them to start to think, 'Well maybe I have a problem.' " And [00:15.00.00] if you reach that goal, it's a powerful thing. It's something that, unfortunately, there's not a lot of room in most treatment programs to sit back and work with patients like that. And of course they drop out completely or you see them all the time. And I think once you can get them to up the stage a little bit, and take a little bit of time with them, then that will pay off. I hope that answered your question. [00:15.20.00] Okay, does anybody else have a question? Right there?

In a residential rehab setting like at PTSD where they can only stay for two or three months and if they're at the precontemplation stage where they don't have that time [00:15.40.00] to develop the rapport and are expected to meet certain, you know, program treatment goals, would you just be spending that time with them in that stage or are they just not a good fit perhaps then with that kind of treatment at that point in time?

They may not be a good fit, right? They may not be a good fit [00:16.00.00] and that's something that has to be considered that really some of the inpatient programs should only take contemplators and above, 'cause you're wasting a lot of people's time. Now if it's only one or two problems—and one thing I've not emphasized enough is that, you know, I'm not talking about people who believe they have PTSD or not. I mean, I'm talking about guys who believe they have [00:16.20.00] PTSD. It's usually a particular problem or two, maybe more. So, I think there has to be some room in the program for a guy to say, "You know I just think that my way of seeing the world is appropriate." And then having some place to have a discussion. There's lots of room in programs like [00:16.40.00] Menlo to have discussion with patients about things they're going through. And certainly one of them can be their ambivalence about maybe this anger stuff they just kind of don't buy it. Process groups, I think that would be an excellent place to allow that kind of discussion to occur. Case management. And then of course if you open that up what you find like in most things [00:17.00.00] especially the Menlo program, the guys are working with each other and helping each other. I think one of the great things about programs like Menlo is that peer support is so powerful. So, I think there definitely are places, but there has to be a little more of a culture for that to be expressed in public in groups. And then again I think process groups, focus groups—[00:17.20.00] because in focus groups you're going to see why people feel that way. And I think it's important to make those ties too. Is that, is that helpful?

Mm-hmm.

Any other comments or questions? Okay, let's go to the next part. [00:17.40.00]

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